

**THE INSURANCE CODE OF 1956 (EXCERPT)**

**Act 218 of 1956**

**CHAPTER 36**

**GROUP AND BLANKET DISABILITY INSURANCE**

**500.3600 Scope of chapter.**

Sec. 3600. (1) This chapter shall apply only to group, blanket, and family expense disability insurance policies.

(2) Nothing in this chapter shall apply to or affect:

(a) Any policy of liability or workmen's compensation insurance, with or without supplementary expense coverage therein;

(b) Any policy or contract of reinsurance; or

(c) Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to disability insurance as (i) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (ii) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

**History:** 1956, Act 218, Eff. Jan. 1, 1957.

**Popular name:** Act 218

**500.3601 "Group disability insurance" defined.**

Sec. 3601. Group disability insurance is hereby declared to be that form of voluntary disability insurance covering not less than 5 employees or members, with or without their eligible dependents, written under a master policy issued to any governmental corporation, unit, agency, or department thereof, or to any corporation, copartnership, individual employer, or any association, upon application of any executive officer or trustee of such association having a constitution or bylaws, and formed in good faith for purposes other than that of obtaining insurance where officers, members, employees, or classes or departments thereof may be insured for their individual benefit.

**History:** 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1990, Act 126, Imd. Eff. June 26, 1990.

**Popular name:** Act 218

**500.3601a Group disability insurance policy; issuance to trust or trustees; requirements.**

Sec. 3601a. Notwithstanding section 3601, a group disability insurance policy may be issued to a trust or trustees of a fund established by 2 or more employers to insure 1 or more employees of the employers.

**History:** Add. 1988, Act 312, Eff. Mar. 30, 1989.

**Popular name:** Act 218

**500.3602 Exemption as to workmen's compensation insurance.**

Sec. 3602. Nothing in this chapter shall be construed to apply to group insurance covering accidental injuries or accidental death arising out of and in the course of employment written under a policy issued to any governmental corporation, unit, agency or department thereof, or to any corporation, copartnership, individual employer, or any association upon application of any executive officer, board, or trustee of such association having a constitution or bylaws, and formed in good faith for purposes other than that of obtaining insurance where officers, members, or employees thereof are insured for their individual benefit.

**History:** 1956, Act 218, Eff. Jan. 1, 1957.

**Popular name:** Act 218

**500.3606 Power to issue group disability insurance policies; filing and approval of form.**

Sec. 3606. (1) An insurer authorized to write disability insurance in this state shall have the power to issue group disability insurance policies.

(2) Except as otherwise provided in section 2236(8)(d), a group disability insurance policy shall not be issued or delivered in this state unless a copy of the form shall have been filed with the commissioner and approved by him or her.

**History:** 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1987, Act 52, Imd. Eff. June 22, 1987;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

**Compiler's note:** Section 2 of Act 52 of 1987 provides:

"The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act

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Page 1

Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

apply to all insurance policies issued on or after January 1, 1957 that were either approved by the commissioner on or after January 1, 1957 or subject to an order of the commissioner exempting policies from filing on or after September 1, 1968. The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act are intended to codify and approve long-standing administrative and commercial practice taken and approved by the commissioner pursuant to his or her legal authority. This amendatory act shall serve to cure and clarify any misinterpretation of the operation of such sections since the effective date of their original enactment. It is the intent of this amendatory act to rectify the misconstruction of the insurance code of 1956 by the court of appeals in Bill v Northwestern National Life Insurance Company, 143 Mich App 766, with respect to the power of the insurance commissioner to exempt certain insurance documents from filing requirements and the offsetting of social security benefits against disability income insurance benefits. This amendatory act does not affect the relationship between disability insurance benefits and personal protection insurance benefits as provided in Federal Kemper v Health Insurance Administration Inc., 424 Mich 537.”

**Popular name:** Act 218

**500.3607 Replacement group disability insurance policy or certificate with preexisting condition limitation; elimination, reduction, or limitation of benefits; applicability of section to in-state resident; “disability coverage” and “disability insurance policy” defined.**

Sec. 3607. (1) If existing group disability coverage is replaced by a group disability insurance policy or certificate with a preexisting condition limitation and insuring 10 or more employees or members, coverage in the replacement policy or certificate applicable to the preexisting condition limitation for an individual who had been covered for that condition by the replaced coverage shall be not less than the lesser of the following:

(a) The coverage of the replacement policy or certificate without application of the preexisting condition limitation.

(b) The benefits of the replaced group disability coverage until the individual's preexisting condition limitation expires under the replacement policy or certificate.

(2) Other than as provided in subsection (1), a replacement group disability insurance policy or certificate insuring 10 or more employees or members shall not include a limitation upon an individual or exclude an individual who was covered by the group disability coverage being replaced if the individual is a member of the class or classes of individuals eligible for coverage under the replacement policy or certificate.

(3) If existing group disability coverage issued or renewed on or after January 1, 1992 is replaced by a group disability insurance policy or certificate with a preexisting condition limitation and insuring less than 10 employees or members, the replaced coverage shall extend benefits for the condition excluded by the replacement policy or certificate because of the application of a preexisting condition limitation by providing benefits for that condition until the term of the preexisting condition limitation has expired or 6 months have elapsed, whichever occurs first. An individual not covered for a condition under replaced group disability coverage because the term of a preexisting condition limitation has not expired is covered for that condition under the replaced coverage pursuant to this subsection when the term of the preexisting condition limitation in the replaced coverage expires. If there is a dispute between the replacement carrier and the replaced carrier as to whether an individual's condition is included within a preexisting condition limitation, benefits shall be paid by the replacement carrier pending resolution of the dispute. This subsection applies only to the extent that benefits would have been available for the preexisting condition under the replaced coverage. This subsection applies only if the replaced master coverage has been in effect for at least 6 months.

(4) If existing group disability coverage issued or renewed on or after January 1, 1992 is replaced by a group disability insurance policy or certificate with a preexisting condition limitation and insuring less than 10 employees or members, the replacement policy or certificate shall not include a limitation for a period exceeding 6 months upon an individual or exclude an individual who was covered by the group disability coverage being replaced if the individual is a member of the class or classes of individuals eligible for coverage under the replacement policy or certificate.

(5) This section does not preclude an elimination, reduction, or limitation of benefits that applies to an entire plan. This section applies to individuals who are covered under the replaced policy or certificate at the time of replacement and does not apply to individuals who become eligible for or apply for coverage under a replacement group disability policy or certificate after that replacement policy or certificate is issued.

(6) This section applies whenever an individual residing in the state of Michigan is covered by existing group disability coverage that is being replaced, regardless of the state in which the replacement policy or certificate is issued.

(7) As used in this section:

(a) “Disability coverage” means expense-incurred hospital, medical, or surgical coverage.

(b) “Disability insurance policy or certificate” means an expense-incurred hospital, medical, or surgical insurance policy or certificate.

**History:** Add. 1989, Act 255, Eff. Jan. 1, 1992;—Am. 1994, Act 180, Imd. Eff. June 20, 1994.

Rendered Wednesday, January 14, 2009

Page 2

Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

**Popular name:** Act 218

### **500.3608 Group disability insurance policy; required provisions.**

Sec. 3608. Every policy of group disability insurance shall contain:

(1) A provision that the policy, application of the employer, or executive officer or trustee of any association, and the individual applications, if any, of the employees or members insured, shall constitute the entire contract between the parties, and that all statements made by the employer, or the executive officer or trustee, or by the individual employees or members, shall, in the absence of fraud, be deemed representations and not warranties, and that the statements shall not be used in defense of a claim under the policy, unless they are contained in a written application.

(2) A provision that the insurer will issue to the employer, or to the executive officer or trustee of the association, for delivery to the employee or member, who is insured under the policy, an individual certificate setting forth a statement as to the insurance protection to which he is entitled and to whom payable.

(3) A provision that to the group or class thereof originally insured shall be added from time to time all new employees of the employer, or members of the association eligible to, and applying for insurance in the group or class.

**History:** 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1974, Act 50, Eff. July 1, 1974.

**Popular name:** Act 218

### **500.3609 Expired. 1980, Act 429, Eff. Jan. 1, 1982.**

**Compiler's note:** The expired section pertained to coverage for treatment of alcoholism and drug abuse.

**Popular name:** Act 218

### **500.3609a Group disability insurance policy; substance abuse; effective date of section.**

Sec. 3609a. (1) An insurer which delivers, issues for delivery, or renews in this state a policy of group disability insurance shall offer to include in that policy a provision that the insurer will provide coverage for inpatient care for substance abuse to the extent agreed upon between the insured employer or other insured organization and the insurer, to be provided in a facility approved by the department of public health for hospitalization or treatment of substance abuse. This coverage shall be subject to the provisions of sections 3406 to 3466, except sections 3425, 3438, and 3440.

(2) An insurer which delivers, issues for delivery, or renews in this state a policy of group disability insurance shall include in that policy a provision that the insurer will provide coverage for intermediate and outpatient care for substance abuse, to the extent required by section 3425.

(3) This section shall take effect January 1, 1982.

**History:** Add. 1980, Act 429, Eff. Jan. 1, 1982;—Am. 1984, Act 65, Imd. Eff. Apr. 18, 1984.

**Popular name:** Act 218

### **500.3610 Group disability insurance policy; mandatory provisions.**

Sec. 3610. Every policy of group disability insurance shall contain the applicable provisions required in sections 3406 through 3466, except sections 3438 and 3440. Beginning January 1, 1957, sections 3438 and 3440 do not apply to group disability insurance policies, except policies, or those portions of policies, that establish a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles pursuant to section 3109a.

**History:** Add. 1974, Act 225, Eff. Nov. 1, 1974;—Am. 1984, Act 65, Imd. Eff. Apr. 18, 1984;—Am. 1987, Act 52, Imd. Eff. June 22, 1987.

**Compiler's note:** Section 2 of Act 52 of 1987 provides:

"The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act apply to all insurance policies issued on or after January 1, 1957 that were either approved by the commissioner on or after January 1, 1957 or subject to an order of the commissioner exempting policies from filing on or after September 1, 1968. The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act are intended to codify and approve long-standing administrative and commercial practice taken and approved by the commissioner pursuant to his or her legal authority. This amendatory act shall serve to cure and clarify any misinterpretation of the operation of such sections since the effective date of their original enactment. It is the intent of this amendatory act to rectify the misconstruction of the insurance code of 1956 by the court of appeals in Bill v Northwestern National Life Insurance Company, 143 Mich App 766, with respect to the power of the insurance commissioner to exempt certain insurance documents from filing requirements and the offsetting of social security benefits against disability income insurance benefits. This amendatory act does not affect the relationship between disability insurance benefits and personal protection insurance benefits as provided in Federal Kemper v Health Insurance Administration Inc., 424 Mich 537."

**Popular name:** Act 218

### **500.3610a Coordination of benefits.**

Sec. 3610a. (1) A group disability insurance policy may contain provisions for the coordination of benefits otherwise payable under the policy with benefits payable for the same loss under other group insurance; automobile medical payments insurance; or coverage provided on a group basis by hospital, medical, or dental service organizations, by union welfare plans, or employee or employer benefit organizations.

(2) If a group disability insurance policy contains a coordination of benefits provision, the benefits shall be payable pursuant to the coordination of benefits act.

**History:** Add. 1984, Act 65, Imd. Eff. Apr. 18, 1984.

**Popular name:** Act 218

### **500.3611 Group disability insurance policy; coverage for newly born children; notice of birth; payment of premium.**

Sec. 3611. (1) All group disability insurance policies providing coverage on an expense incurred basis which provide coverage for a family member of the insured shall, as to that family member's coverage, also provide that the disability insurance benefits applicable for children shall be payable with respect to a newly born child of the insured from the moment of birth.

(2) The coverage for children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of a newly born child and payment of the required premium shall be furnished to the insurer within 31 days after the date of birth in order to have the coverage continue beyond the 31-day period.

**History:** Add. 1975, Act 20, Imd. Eff. Apr. 3, 1975.

**Compiler's note:** Section 2 of Act 20 of 1975 provides: "The requirements of this act shall apply to all insurance policies delivered or issued for delivery in this state more than 120 days after the effective date of the act."

**Popular name:** Act 218

### **500.3612 Individual conversion policy.**

Sec. 3612. (1) An expense-incurred hospital, medical, surgical, or sick-care group disability insurance policy issued or renewed in this state after December 31, 1990, shall include provisions consistent with this section.

(2) If an individual member has been continuously covered under a group policy for at least 3 months immediately prior to termination, the individual member and his or her covered spouse and dependents may elect coverage under an individual conversion policy upon termination. As used in this section, termination includes, but is not limited to, the following:

(a) Discontinuance of a group policy in its entirety or with respect to an insured class.

(b) Loss of expense-incurred hospital, medical, surgical, or sick-care insurance coverage due to voluntary or involuntary termination of employment except for termination of employment because of gross misconduct.

(c) For a surviving spouse or dependent, death of an individual member covered under a group policy.

(d) An event that causes a person, who is a spouse or dependent of an individual member at the time of the event, to cease to be a qualified family member under a group policy.

(3) Coverage under an individual conversion policy shall take effect immediately upon the termination of coverage under the group policy.

(4) Notification of the conversion privilege shall be included in each policy and certificate of coverage.

(5) A group policyholder shall give written notice to an individual member of the option to elect an individual conversion policy within 14 days after the occurrence of subsection (2)(a) or (b).

(6) An individual member shall notify the insurer of his or her election to convert to an individual conversion policy not later than 30 days after termination of coverage. The first premium shall be paid to the insurer at the time the individual elects to convert to an individual conversion policy.

(7) An individual conversion policy under this section:

(a) Shall be issued without evidence of insurability.

(b) Shall not use conditions pertaining to health as a basis for classification.

(c) Shall not exclude a preexisting condition that is not excluded by the group policy solely because it is a preexisting condition.

(d) May provide that benefits may be reduced by the amount of benefits paid for a specific covered service pursuant to the group policy or certificate that has been terminated.

(8) The premium for an individual conversion policy under this section shall be determined using the

aggregate experience for all such policies issued in this state by the insurer and in accordance with premium rates applicable to the age, class of risk, and the type and amount of coverage provided. The experience of an individual under an individual conversion policy shall not be an acceptable basis for establishing that individual's rate for his or her converted policy.

(9) An insurer is not required to issue an individual conversion policy under this section if any of the following circumstances apply:

(a) The individual is covered for similar benefits and to a similar extent by another expense-incurred hospital, medical, surgical, or sick-care insurance policy or certificate, hospital or medical service subscriber contract, medical practice or other prepayment plan, or other expense-incurred plan or program.

(b) The individual is covered under title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-1a to 1395i-3, 1395j to 1395dd, 1395ff to 1395mm, and 1395oo to 1395ccc.

(c) If termination of an individual's coverage under a group policy occurred because of any of the following:

(i) The individual failed to pay any required contribution.

(ii) Discontinued group coverage was replaced by group coverage.

(iii) The individual acted to defraud the insurer.

(10) An individual conversion policy under this section delivered outside this state for a group policy that was issued and delivered in this state shall comply with this section.

**History:** Add. 1989, Act 259, Imd. Eff. Dec. 26, 1989.

**Popular name:** Act 218

#### **500.3613 Group hospital, medical, or surgical expense incurred policy; mastectomy benefit coverage required.**

Sec. 3613. A group hospital, medical or surgical expense incurred policy shall provide benefits for prosthetic devices to maintain or replace the body parts of an individual who has undergone a mastectomy. This coverage shall provide that reasonable charges for medical care and attendance for an individual who receives reconstructive surgery following a mastectomy or who is fitted with a prosthetic device shall be covered benefits after the individual's attending physician has certified the medical necessity or desirability of a proposed course of rehabilitative treatment. The cost and fitting of a prosthetic device following a mastectomy is included within the type of coverage intended by this section.

**History:** Add. 1982, Act 527, Eff. Mar. 30, 1983.

**Popular name:** Act 218

#### **500.3614 Coverage for mental health services by mental health care provider.**

Sec. 3614. A policy or certificate which provides coverage for mental health services shall provide coverage for mental health services provided to an individual by a mental health care provider operated by or under contract with the department of mental health or a county community mental health board in those instances when appropriate mental health services cannot be delivered otherwise, or if the provider of the mental health services is designated by an order of a court; provided that the mental health provider meets the standards set by the insurer for all other providers of the type.

**History:** Add. 1984, Act 280, Imd. Eff. Dec. 20, 1984.

**Popular name:** Act 218

#### **500.3615 Hospice care; definition; description of coverage.**

Sec. 3615. (1) An insurer that delivers, issues for delivery, or renews in this state an expense-incurred group hospital, medical, or surgical policy that provides coverage for inpatient hospital care shall offer to include coverage for hospice care. As used in this section, "hospice" means hospice as defined in section 20106 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.20106 of the Michigan Compiled Laws.

(2) If hospice care coverage is provided, a description of the hospice coverage shall be included in communications sent to the insured or group purchaser of coverage.

**History:** Add. 1984, Act 368, Eff. Jan. 1, 1986;—Am. 1994, Act 233, Imd. Eff. June 30, 1994.

**Popular name:** Act 218

#### **500.3616 Coverage for breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services; coverage for breast cancer screening mammography; definitions; effective date of section.**

Sec. 3616. (1) Subject to dollar limits, deductibles, and coinsurance provisions that are not less favorable than those for physical illness generally, an insurer which delivers, issues for delivery, or renews in this state a group hospital, medical, or surgical expense incurred policy shall offer or include coverage for breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services.

(2) Subject to dollar limits, deductibles, and coinsurance provisions that are not less favorable than those for physical illness generally, an insurer which delivers, issues for delivery, or renews in this state a hospital, medical, or surgical expense incurred policy shall offer or include the following coverage for breast cancer screening mammography:

(a) If performed on a woman 35 years of age or older and under 40 years of age, coverage for 1 screening mammography examination during that 5-year period.

(b) If performed on a woman 40 years of age or older, coverage for 1 screening mammography examination every calendar year.

(3) As used in this section:

(a) "Breast cancer diagnostic services" means a procedure intended to aid in the diagnosis of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to mammogram, mammography, surgical breast biopsy, and pathologic examination and interpretation.

(b) "Breast cancer rehabilitative services" means a procedure intended to improve the result of, or ameliorate the debilitating consequences of, treatment of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to reconstructive plastic surgery, physical therapy, and psychological and social support services.

(c) "Breast cancer screening mammography" means a standard 2-view per breast, low-dose radiographic examination of the breasts, using equipment designed and dedicated specifically for mammography, in order to detect unsuspected breast cancer.

(d) "Breast cancer outpatient treatment services" means a procedure intended to treat cancer of the human breast, delivered on an outpatient basis, including but not limited to surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

(4) This section shall take effect November 1, 1989.

**History:** Add. 1989, Act 59, Eff. Nov. 1, 1989.

**Popular name:** Act 218

#### **500.3616a Coverage for drug used in antineoplastic therapy and cost of its administration; conditions.**

Sec. 3616a. An insurer which delivers, issues for delivery, or renews in this state a hospital, medical, or surgical expense incurred policy shall provide coverage in each policy for a federal food and drug administration approved drug used in antineoplastic therapy and the reasonable cost of its administration. Coverage shall be provided regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the federal food and drug administration if all of the following conditions are met:

(a) The drug is ordered by a physician for the treatment of a specific type of neoplasm.

(b) The drug is approved by the federal food and drug administration for use in antineoplastic therapy.

(c) The drug is used as part of an antineoplastic drug regimen.

(d) Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.

(e) The physician has obtained informed consent from the patient for the treatment regimen which includes federal food and drug administration approved drugs for off-label indications.

**History:** Add. 1989, Act 59, Imd. Eff. June 16, 1989.

**Popular name:** Act 218

#### **500.3620 Family expense insurance; definition; authority to issue; form; provisions; risk classification and rates.**

Sec. 3620. (1) Family expense insurance is that form of accident and health or hospitalization, medical, surgical and sick-care insurance which is written under 1 policy issued to the head of a family who may be either spouse, and insuring such head and 1 or more dependents, and may include a non-dependent spouse. Benefits under such policy, except as applied to the head of the family, shall not include indemnities for loss of time from any cause.

(2) Any insurer authorized to write accident and health or hospitalization, medical, surgical and sick-care insurance in this state is authorized to issue family expense insurance policies.

(3) No such policy may be issued or delivered in this state unless a copy of the form thereof shall have

been filed with the commissioner and approved by him.

(4) Every policy of family expense insurance shall contain the applicable provisions of sections 3406 through 3466 (required and optional provisions for individual disability insurance policies), and shall contain the following provisions in substance:

(a) A provision that the policy and the application signed by the husband or wife acting as the head of the family for the purpose of this insurance shall constitute the entire contract between the parties, and that all statements made by the head of the family shall, in the absence of fraud, be deemed representations and not warranties, and that no statement shall be used in defense of a claim under the policy unless it is contained in a written application.

(b) A provision that to the family group originally insured may be added, from time to time, on application of the head of the family, any new members of the family eligible for insurance in such family group.

(5) Such policies shall be subject to section 3474 (filing of risk classifications and rates).

**History:** 1956, Act 218, Eff. Jan. 1, 1957.

**Popular name:** Act 218

### **500.3630 Hospital, medical, surgical, sick-care benefits; payment.**

Sec. 3630. In any disability group policy or family expense policy providing for hospital, medical, surgical and/or sick-care benefits, all benefits accruing under such policy for or on account of any member of a family included therein shall be payable to the insured, if living, or to such other person as the policy may provide for in the case of the insured's death, but it may be provided in the policy, with the consent of the insured, that the said benefits in any case may be paid directly to any corporation furnishing hospital, and to any person legally furnishing medical, surgical, or sick-care services to the insured or to the members of his or her family covered in the policy, within such limits as the policy may provide, but without other preferences as to such creditors: Provided, That in the case of family insurance, one of the parents, or the person who stands in the place of parent, shall be the contracting party for such insurance, and may receive, receipt and give acquittance for all benefits accruing to any member of such family so insured.

**History:** 1956, Act 218, Eff. Jan. 1, 1957.

**Popular name:** Act 218

### **500.3631 Prudent purchaser agreements with providers of hospital, nursing, medical, surgical, or sick-care services; group disability insurance or family expense insurance; options; applicability of subsection (3); realization of financial or other advantage; applicability of subsection (5); rates; discrimination prohibited; prior contracts and renewal; optometric and chiropractic service; conditional effective date of subsection (11).**

Sec. 3631. (1) For the purpose of doing business as an organization under the prudent purchaser act, Act No. 233 of the Public Acts of 1984, being sections 550.51 to 550.63 of the Michigan Compiled Laws, an insurer authorized to write group disability insurance or family expense insurance that provides coverage for hospital, nursing, medical, surgical, or sick-care benefits may enter into prudent purchaser agreements with providers of hospital, nursing, medical, surgical, or sick-care services pursuant to this section and Act No. 233 of the Public Acts of 1984.

(2) An insurer may offer group disability insurance policies or family expense policies under which the insured persons shall be required, as a condition of coverage, to obtain hospital, nursing, medical, surgical, or sick-care services exclusively from health care providers who have entered into prudent purchaser agreements.

(3) An individual who is a member of a group who is offered the option of being under a policy pursuant to subsection (2) shall also be offered the option of being insured under a policy pursuant to subsection (4). This subsection applies only if the group in which the individual is a member has 25 or more members or if the provider panel that is providing the services under the group policy is limited by the organization to a specific number pursuant to section 3(1) of Act No. 233 of the Public Acts of 1984, being section 550.53 of the Michigan Compiled Laws.

(4) An insurer may offer group disability insurance policies or family expense policies under which insured persons who elect to obtain hospital, nursing, medical, surgical, or sick-care services from health care providers who have entered into prudent purchaser agreements shall realize a financial advantage or other advantage by selecting such a provider. Policies offered pursuant to this subsection shall not, as a condition of coverage, require insured persons to obtain such services exclusively from health care providers who have entered into prudent purchaser agreements.

(5) An individual who is a member of a group who is offered the option of being insured under a policy pursuant to subsection (2) or (4) shall also be offered the option of being insured under a policy that:

(a) Does not, as a condition of coverage, require insured persons to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not give a financial advantage or other advantage to an insured person who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(6) Subsection (5) applies only if the group in which the individual is a member has 25 or more members and if the group on December 20, 1984 had health care coverage through the group sponsor.

(7) The rates charged by an insurer for coverage under policies issued under this section shall not be unreasonably lower than what is necessary to meet the expenses of the insurer for providing this coverage and shall not have an anticompetitive effect or result in predatory pricing in relation to prudent purchaser agreement coverages offered by other organizations.

(8) An insurer shall not discriminate against a class of health care providers when entering into prudent purchaser agreements with health care providers for its provider panel. This subsection does not:

(a) Prohibit the formation of a provider panel consisting of a single class of providers when a service provided for in the specifications of a purchaser may legally be provided only by a single class of providers.

(b) Prohibit the formation of a provider panel that conforms to the specifications of a purchaser of the coverage authorized by this section so long as the specifications do not exclude any class of health care providers who may legally perform the services included in the coverage.

(c) Require an organization that has uniformly applied the standards filed pursuant to section 3(3) of Act No. 233 of the Public Acts of 1984, being section 550.53 of the Michigan Compiled Laws, to contract with any individual provider.

(9) Nothing in this 1984 amendatory act applies to any contract that is in existence before December 20, 1984, or the renewal of such contract.

(10) Notwithstanding any other provision of this act, if coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of optometry, an insurer is not required to provide coverage or reimburse for a practice of optometric service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.17401 of the Michigan Compiled Laws, as of May 20, 1992.

(11) Notwithstanding any other provision of this act, if coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of chiropractic, an insurer is not required to provide coverage or reimburse for the use of therapeutic sound or electricity, or both, for the reduction or correction of spinal subluxations in a chiropractic service. This subsection shall not take effect unless Senate Bill No. 493 of the 87th Legislature is enacted into law.

**History:** Add. 1984, Act 280, Imd. Eff. Dec. 20, 1984;—Am. 1989, Act 137, Eff. Jan. 3, 1990;—Am. 1994, Act 438, Eff. Mar. 30, 1995.

**Compiler's note:** Senate Bill No. 493 was not enacted into law by the 87th Legislature.

**Popular name:** Act 218

### **500.3636 Blanket disability insurance; definition.**

Sec. 3636. Blanket disability insurance is hereby declared to be that form of disability insurance covering special groups of persons as enumerated in the following subdivisions (1) to (7) inclusive:

(1) Under a policy or contract issued to any common carrier, which shall be deemed the policyholder, covering a group defined as all persons who may become passengers on such common carrier.

(2) Under a policy or contract issued to an employer, who shall be deemed the policyholder, covering all employees or any group of employees defined by reference to exceptional hazards incident to such employment.

(3) Under a policy or contract issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or teachers.

(4) Under a policy or contract issued in the name of any volunteer fire department, first aid or other such volunteer group, which shall be deemed the policyholder, covering all of the members of such department or group.

(5) Under a policy or contract issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditors.

(6) Under a policy or contract issued to a sports team or to a camp, which team or camp sponsor shall be deemed the policyholder, covering members or campers.

(7) Under a policy or contract issued to any other substantially similar group which, in the discretion of the commissioner, may be subject to the issuance of a blanket disability policy or contract.

**History:** 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

**500.3638 Blanket disability insurance; insurer, power to issue; filing, approval, classifications, rates.**

Sec. 3638. (1) Any insurer authorized to write disability insurance in this state shall have the power to issue blanket disability insurance policies.

(2) No such blanket policy may be issued or delivered in this state unless a copy of the form shall have been filed with the commissioner and approved by him.

(3) Such policies shall also be subject to section 3474 (filing of risk classifications and rates).

**History:** 1956, Act 218, Eff. Jan. 1, 1957.

**Popular name:** Act 218

**500.3640 Blanket disability insurance policy; provisions required.**

Sec. 3640. Every policy of blanket disability insurance shall contain the following provisions:

(1) A provision that the policy and the application of the policyholder shall constitute the entire contract between the parties, and that all statements made by the policyholder shall, in the absence of fraud, be deemed representations and not warranties, and that no such statements shall be used in defense of a claim under the policy, unless it is contained in a written application.

(2) A provision that to the group or class thereof originally insured shall be added from time to time all new persons or individuals eligible for coverage.

(3) The applicable provisions of sections 3406 through 3466 (required and optional provisions for individual disability insurance policies).

**History:** 1956, Act 218, Eff. Jan. 1, 1957.

**Popular name:** Act 218

**500.3650 Blanket disability insurance; application; certificate; payment of benefits; liability of policyholder.**

Sec. 3650. (1) An individual application shall not be required from a person covered under a blanket disability policy or contract. The commissioner may require the insurer to furnish a certificate to each person insured under a blanket disability policy or contract.

(2) All benefits under any blanket disability policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate, except that if the person insured be a minor or mental incompetent, such benefits may be made payable to his parent, guardian or other person actually supporting him. The policy may provide, with the consent of the insured, that the benefits in any case may be paid directly to any corporation furnishing hospital, and to any person legally furnishing medical, surgical or sick-care services to the insured, within such limits as the policy may provide, but without other preference as to such creditors.

(3) Nothing contained in sections 3636 through 3650 shall be deemed to affect the legal liability of policyholders for the death of or injury to, any such member of such group.

**History:** 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1963, Act 127, Eff. Sept. 6, 1963.

**Popular name:** Act 218